MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 53

09447

CERTIFICATE OF DEATH

Reg. Dist. No. 81.

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Broadway St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Bridge Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Broadway St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George William Abbott

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed

B (b) Name of husband or wife Anna Rebecca Gosnell

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 25 - 1864

8. AGE: Years 76 | Months 4 | Days 10 | If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore Co, Maryland
(Town, county, and state)
10. Usual occupation Lumber Inspector
11. Industry or business Western Maryland Railway

FATHER
12. Name David Abbott
13. Birthplace Baltimore Co, Maryland

MOTHER
14. Maiden name Lucinda Barnes
15. Birthplace Washington Co, Maryland

16. Informant Miss Reba Abbott
Address Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 8-1940. (month) (day) (year)
Cemetery or crematory Methodist Cemetery
Location Patapsco, Maryland.

18. Funeral director D. D. Hartzl & Sons
Address Union Bridge, Md.

19. Sept. 7, 1940 (Date rec'd by registrar) P. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1940 at 11.45 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1940, to Sept. 1940 and that I last saw him alive on Sept 4 1940

Immediate cause of death Carcinoma of Face

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J H Messler M.D. M. D. or other
Address Johnsville Date signed Sept 7, 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 5 1940
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

CERTIFICATE OF DEATH

09448

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield Hospital
Stay in hospital or inst. (yrs., or mos., or days): 6 weeks
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Sykesville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles Lowdnes Bennett

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Jemima Bennett
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 3rd, 1866

8. AGE: Years	Months	Days	If less than one day
74	8	15	hrs. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Book-keeper (Retired)
11. Industry or business

FATHER
12. Name: John Wm. Bennett
13. Birthplace: Md.

MOTHER
14. Maiden name: Sarah Lloyd Lowdnes
15. Birthplace: Md.

16. Informant: Mrs. Jemima Bennett
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 20, 1940 (month) (day) (year)
Cemetery or crematory: Springfield
Location: Sykesville, Md.

18. Funeral director: C. H. Weer
Address: Sykesville, Md.

19. Sept. 18 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18, 1940 at 11-30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1940, to death 19; and that I last saw him alive on Sept 17 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	Several yrs.
Chronic Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operation:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. H. Lamont, M.D. M. D. or other
Address: Sept 19, 1940 Sykesville, Md.

RECEIVED
OCT 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09449

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 18 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 4 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore, (If outside city or town limits, write RURAL and give nearest town)
Street No. 1805 Jefferson (If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: VIVIAN CECELIA BENNETT

3.(b) Social Security Number: 215-16-9846

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 5, 1920

8. AGE: Years	Months	Days	If less than one day
19	11	9	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Presser
11. Industry or business: Unknown
FATHER 12. Name: William Bennett
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Bennett
15. Birthplace: Baltimore, Maryland
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/16/40 (month) (day) (year)
Cemetery or crematory: St. Peters Cem
Location: Baltimore, Md
18. Funeral director: Joseph L. Locks, Jr.
Address: 1204 N. Central Ave.
19. Sept. 14 1940 (Date rec'd by registrar) Albert R. Swanbaum Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 1940, at 4:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27, 1940, to September 14 1940 and that I last saw her alive on September 14 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1940
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op.: --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Superintendent
Address: Henryton, Maryland Date signed: 9/14/40

RECEIVED
SEP 21 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

09450

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 1 mo., 28 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital.
How long in hospital or institution? 1 yr., 1 mo., 28 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore.
(If outside city or town limits, write RURAL and give nearest towo)
Street No. 1628 East 28th Street.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: James William Bowers.

3. (b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Married.

6.(b) Name of husband or wife: Sarah E. Turner.
6.(c) If alive, give age: Unk. years

7. Birth date of deceased (mo., day, yr.): July 7, 1868.

8. AGE: Years 72. Months 2. Days 21. If less than one day: hrs. min.

9. Birthplace: Carroll Co., Md. (Town, county, and state)
10. Usual occupation: Card Grinder.
11. Industry or business: Textile Mill.
FATHER 12. Name: James Bowers.
13. Birthplace: Unknown.
MOTHER 14. Maiden name: Julie Ann Schaeffer.
15. Birthplace: Unknown.
16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 2 1940 (month) (day) (year)
Cemetery or crematory: New Market Cem.
Location: New Market Balto Co. Md.
18. Funeral director: Horace L. Burgee.
Address: 3621 Falls Road Balto
19. Sept 28 1940 (Date rec'd by registrar) C. Harry Wenz Registror

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28, 1940 at 10:25 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28, 1939, to Sept. 28, 1940.
and that I last saw him alive on Sept. 28, 1940.
Immediate cause of death: Cerebral Haem- -orrhage - DURATION 2 days.
Due to: Cerebral Arteriosclerosis prior to 7-31-39.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M. D.
M. D. or other
Address: Sykesville, Md. Date signed: 7-28-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09451

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 9 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 6 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 Cathel Street
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: WILLIAM BENJAMIN BREWINGTON

3.(b) Social Security Number: 213-16-8141

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 11, 1922

8. AGE: Years	Months	Days	If less than one day
18	0	21	hrs. min.

9. Birthplace: Salisburg, Maryland (Town, county, and state)
10. Usual occupation: Presser
11. Industry or business: Unknown
FATHER 12. Name: Henry Purnell
13. Birthplace: Salisbury, Maryland
MOTHER 14. Maiden name: Alice Brewington
15. Birthplace: Salisbury, Maryland
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4, 1940 (month) (day) (year)
Cemetery or crematory: Hanston
Location: Salisbury Md
18. Funeral director: James F. Stewart
Address: Salisbury md
19. Sept. 1 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1 1940 at 3:00P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23 1940 to Sept. 1 1940
and that I last saw h...im alive on September 1 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan 1940
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)
Major findings of operations: --
Date of op. --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Superintendent
Address: Henryton, Maryland Date signed: 9/1/40

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

Birth cert
Aug 30

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-a)

09452

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County Carroll

City or town Rural Near Lineboro
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Near Lineboro Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Ruth E. Brighner

3. (b) Social Security Number ✓

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30. 1940

8. AGE: Years ✓ Months ✓ Days 21 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation At. Home

11. Industry or business

FATHER
12. Name George Brighner
13. Birthplace Penna.

MOTHER
14. Maiden name Erma R Dub.
15. Birthplace Penna.

16. Informant George Brickner
Address Lineboro Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-40 (month) (day) (year)

Cemetery or crematory cemetery

Location Black Rock Pa.

18. Funeral director Jacob Wink's Sons
Address Manchester Md

19. Sept. 23 1940 Mrs. H. G. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 31 1940, to Sept 21 1940, and that I last saw h[illegible] alive on Sept 21 1940.

Immediate cause of death Premature Child 7 mos — DURATION 3 wks

Due to

Due to

Other conditions Ac Diarrhoea — 3 days
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W R S Denner
M. D. or other
Address Manchester Md Date signed 9/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) (C)

RECEIVED
OCT 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (45-A)

09453

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 20 Bond St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 77 2 26

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 20 Bond St.
(if rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edward P. Brundige

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of ~~husband or~~ wife Caroline Starr Brundige
6(c) If alive, give age about 70 years

7. Birth date of deceased (mo., day, yr.) June 23 - 1863

8. AGE: Years	Months	Days	If less than one day
77	2	22	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Merchant
11. Industry or business
FATHER 12. Name Charles Brundige
13. Birthplace Md.
MOTHER 14. Maiden name Hannah Price
15. Birthplace Md.
16. Informant Mrs Caroline Starr Brundige
Address 20 Bond St. Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21-1940 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.
18. Funeral director H Bankard & Son
Address Westminster, Md.
19. 9/20 1940 L Elwood Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19th 1940, at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Feb 1st 1937, to Sept. 19th 1940, and that I last saw him alive on Sept. 19th 1940.

Immediate cause of death Carcinoma of Lip, with metastases to various organs.
Due to
Due to
Other conditions none
(Include pregnancy within 3 months of death)
Major findings:
Dt operations
Dt autopsy

DURATION 3½ yrs.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. F. Billingslea M. D. or other
Address Westminster, Md. Date signed 9/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

09454

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1739 N. Broadway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John H. Callahan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence M. Callahan
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): October 9, 1863

8. AGE: Years	Months	Days	If less than one day
76	11	5	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Fruit and Produce

FATHER
12. Name: Timothy Callahan
13. Birthplace: Ireland

MOTHER
14. Maiden name: M. Quinn
15. Birthplace: England

16. Informant: Records of Springfield S. Hos.
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16 1940 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore Md.

18. Funeral director: H. M. Mears & Son.
Address: 805 N. Calvert St.

19. Sept 14 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 1940 at 12:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1940 to September 14 1940 and that I last saw him alive on September 14 1940

Immediate cause of death: Chronic myocarditis and endocarditis — DURATION: Prior to 1936
Due to:
Due to:
Other conditions: General Arteriosclerosis Prior to 1936
Rt. direct inguinal hernia — Unknown
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Alan Jacka M.D.
Address: Springfield State Hospital M. D. or other
Date signed: 9-14-40

RECEIVED
SEP 17 1940
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

09455

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Near Marriottsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 45 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Near Marriottsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John T. Cauthorn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

8 (b) Name of husband or wife Mary A. Cauthorn
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1857

8. AGE:

Years	Months	Days	If less than one day
83	6	29	____ hrs. ____ min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Pearson T. Cauthorn
FATHER 13. Birthplace Va.
MOTHER 14. Maiden name Elizabeth Wayman
MOTHER 15. Birthplace Md.
16. Informant Alex Cauthorn
Address Sykesville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 4, 1940 (month) (day) (year)
Cemetery or crematory Springfield Cemetery
Location Sykesville, Md.
18. Funeral director C. Harry Weer
Address Sykesville, Md.
19. Sept. 3 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1940, at 11 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1937, to Sept 2 1940,
and that I last saw him alive on Sept 2 1940.

Immediate cause of death Myocarditis — DURATION 3 yr
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. A. Barnes M.D.
M. D. or other
Address Sykesville Md Date signed 9/3/40

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09456

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred: Spring Field State Hosp.

How long in hospital or institution? 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: rural.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Arasmenta Chilton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 31st 1848

8. AGE: Years: 92 | Months: 3 | Days: 5 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Francis Chilton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Mary Sharpley
15. Birthplace: Maryland.

16. Informant: John Z Schneider
Address: Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 9, 1940 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Baltimore Md.

18. Funeral director: C. A. Heer

Address: Sykesville Md.

19. Sept. 6 19 40 (Date rec'd by registrar) C. Harvey Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6th 1940, at 4.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1938, to Sept 6 1940 and that I last saw h[illegible] alive on Sept 5th 1940

Immediate cause of death	DURATION
Chronic Hypocardetis	20 yrs
Due to	7
Arterio Sclerosis	20 yrs
Due to Hypertension.	9
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W. J. Waston M. D. or other

Address: Sykesville Md. Date signed: Sept 6th 40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 14 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

09457

CERTIFICATE OF DEATH

Reg. Diat. No. 8-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge (Rural)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge (Rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Scott Orlando Clemson

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Mary Alice Clemson

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Sept. 28 - 1852

8. AGE: Years: 82 Months: 1 Days: 0 If less than one day: hrs. min.

9. Birthplace: Frederick Co, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Indusfry or business: Farm Owner

FATHER
12. Name: John Davis Clemson
13. Birthplace: Frederick Co. Md

MOTHER
14. Maiden name: Rachel Hoy
15. Birthplace: Frederick Co, Md.

16. Informant: Mrs Mary Alice Clemson
Address: Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 1-40 (month) (day) (year)
Cemetery or crematory: Trinity Lutheran Cemetery
Location: Taneytown Md.

18. Funeral directfor: D. D. Hartle & Son
Address: Union Bridge, Md

19. Sept. 30 1940 (Date rec'd by registrar) F. Eichenauer Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1940, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940, to Sept 28 1940
and that I last saw him alive on Sept 28 1940

Immediate cause of death	DURATION
Carcinoma stomach	
Due to	
Due to	
Other conditions: Hematemesis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Elston Long M. D. or other
Address: Walkersville, Md. Date signed: Sept 28, 40

RECEIVED
OCT 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09458

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 15 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 2 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 402 Taylor Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: WILSON MONROE COSTLEY

3.(b) Social Security Number: 215-18-6652

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1921

8. AGE: Years: 19 | Months: 1 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Winfield, Maryland (Town, county, and state)

10. Usual occupation: Delivery Boy

11. Industry or business: Unknown

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Mildred Costley

MOTHER — 15. Birthplace: Winfield, Carroll Co., Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/4/1940 (month) (day) (year)

Cemetery or crematory: Western Star

Location: Catonsville, Md.

18. Funeral director: Mrs Katie R Williams

Address: 3122 N Lehmoeder St

19. Sept. 1 1940 (Date rec'd by registrar) Albert R. Swanbaum Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1, 1940, 10:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 1940, to Sept. 1 1940 and that I last saw him alive on September 1 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 1940

Due to: p --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.

Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 9/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09459

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 17 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch. (same as above)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4680 Falls Road.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME
MARY ELIZABETH DAVIS

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24, 1921

8. AGE: Years	Months	Days	If less than one day
18	5	25	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Unknown
FATHER 12. Name: Thomas Davis
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Lucy Spencer
15. Birthplace: Virginia
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 21 1940 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Balto. Md.
18. Funeral director: Mgr. S. J. Hemsley
Address: 578 W. Biddle St.
19. 9/18/40 (Date rec'd by registrar) 19 Albert R. Swanblade Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 1940 at 3.30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 1, 1939 to Sept., 18 1940 and that I last saw her alive on September 18, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1939
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.:
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 9/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

09460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll

City or town Rural Nr Finksburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Foot of Falls Hill

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4661 Park Heights Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Victor E. De Paola, Jr.

3. (b) Social Security Number 217-07-3149

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 13, 1920

8. AGE:

Years	Months	Days	If less than one day
19	9	25	hrs. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual occupation Steel worker

11. Industry or business

FATHER
12. Name Victor E. De Paola
13. Birthplace Italy

MOTHER
14. Maiden name Edna Cross
15. Birthplace Baltimore, Md

16. Informant Mrs. Edna De Paola
Address Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/10/40 (month) (day) (year)

Cemetery or crematory New Cathedral

Location Baltimore, Md.

18. Funeral director Loring Byers

Address Baltimore, Md.

19. 9/7 1940 L. H. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1940, at 7 A M Prior to

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —, and that I last saw h — alive on — 19 —.

Immediate cause of death: Fractured Skull - Laceration left elbow -

Due to Automobile Accident.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-7-40

Where did injury occur? Finksburg (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Foot of Falls Hill

Means of injury Automobile Accident Injured at work? No.

23. SIGNATURE Jos. T. March - Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed 9-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 12 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83-a)

09461

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll.
City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 yrs., 7 mos., 24 days.
Hospital, institution, or street address where death occurred: Springfield State Hospital.
How long in hospital or institution? 31 yrs., 7 mos., 24 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel.
City or town Pasadena. - Rural (?)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Green Haven Mountain Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter L. Douch.

3.(b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 24, 1878.

8. AGE: Years	Months	Days	If less than one day
62.	2.	0.	..... hrs. ..... min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual occupation Tinner.
11. Industry or business N. C. R. R.
FATHER 12. Name William Douch,
13. Birthplace Maryland.
MOTHER 14. Maiden name Cornelia McCauley,
15. Birthplace Maryland.
16. Informant Springfield Hospital Record,
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 28, 1940 (month) (day) (year)
Cemetery or crematory Springfield Hosp. Cem.
Location Sykesville Md.
18. Funeral director C. Harry Weer
Address Sykesville Md.
19. Sept 25 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1940, at 4:30 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1938, to Sept. 24, 1940.
and that I last saw him alive on Sept. 24, 1940.

Immediate cause of death	DURATION
Cerebral Haemorrhage.	2 hours.
Due to General Arteriosclerosis with Hypertension - prior to 10-1-38.	
Due to	
Other conditions Dementia Praecox prior to 1-30-'09.	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M.D., M. D. or other
Address Sykesville, Md. Date signed 9-24-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) (M)

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09462

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 21 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 3 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 129 Collins St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: QUILLAR EATON

3.(b) Social Security Number: 216-10-9643

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Annie Eaton

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): September 22, 1896

8. AGE:

Years	Months	Days	If less than one day
44	0	0	....hrs. ....min.

9. Birthplace: Henderson, North Carolina (Town, county, and state)

10. Usual occupation: WPA

11. Industry or business: Unknown

FATHER

12. Name: Charles Eaton

13. Birthplace: Henderson, N. C.

MOTHER

14. Maiden name: Unknown

15. Birthplace: Henderson, N. C.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22/1940 (month) (day) (year)

Cemetery or crematory: Elkton Colored

Location: Elkton, Md

18. Funeral director: Joseph R. Frank

Address: North East, Md.

19. Sept. 22 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22 1940 at 9:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1940 to Sept. 22 1940 and that I last saw h... i.m. alive on September 22 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1940

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.: --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Superintendent

Address: Henryton, Maryland Date signed 9/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

FABLE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170-C

09463

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll

City or town Rural Nr Finksburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Foot of Falls Hill

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3816 W. Garrison Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Robert A. Ernst.

3. (b) Social Security Number 215-09-5405 4

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1918

8. AGE:

Years	Months	Days	If less than one day
22	0	5	hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business Dairy

FATHER
12. Name William F. Ernst
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Emma L. Traupe
15. Birthplace Baltimore, Md.

16. Informant Emma L. Ernst

Address Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/10/40 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Baltimore, Md.

18. Funeral director Mrs. Chas. A. G. Rohde

Address Baltimore, Md.

19. 9/7 1940 H. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION Prior to

20. DATE OF DEATH Sept 7. 1940, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —, and that I last saw h — alive on — 19 —.

Immediate cause of death Fractured Skull

Due to Automobile Accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Accident Date of 9-7-40

Where did injury occur? Finksburg (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Foot of Falls Hill

Means of injury Automobile Accident Injured at work? No.

23. SIGNATURE J. T. Marsh Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 9-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 13 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09464

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown (Rural)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Taneytown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Norman B. Fox

3. (b) Social Security Number none

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced married

8 (b) Name of husband or wife Elizabeth Overholtzer Fox

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1886

8. AGE: Years 54 Months 8 Days 2 If less than one day hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Geo W. Fox

13. Birthplace Md

MOTHER 14. Maiden name Sarah E. Beecher

15. Birthplace Pa

16. Informant Mrs Norman Fox

Address Taneytown, Md RD

17. Burial Date thereof Sept 9, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown

18. Funeral director Ott Frost Son

Address Taneytown Md

19. Sept. 9, 1940 Ethele M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1940, at 4 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1940, to Sept 7 1940, and that I last saw him alive on Sept 7 1940.

Immediate cause of death Lobar Pneumonia — DURATION 7 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg MD
M. D. or other

Address Union Bridge Date signed 9-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
OCT 2 1940
BUREAU V. S.

fch-12

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-6)

09465

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Near Westminster - Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Carroll Co Home

Stay in hospital or inst. (yrs., or mos., or days) 28 days

Stay in this community (yrs., or mos., or days) 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Westminster Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Frank

3. (b) Social Security Number

4. Sex: Ml

5. Color or race: Wh

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma Myers

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 7-25-1873

8. AGE: Years: 67 Months: 1 Days: 8 If less than one day ____ hrs. ____ min.

9. Birthplace: Carroll Co Md (Town, county, and state)

10. Usual occupation: Cigar maker

11. Industry or business

FATHER 12. Name: George Frank

13. Birthplace: Md

MOTHER 14. Maiden name: Rachael Cole

15. Birthplace: Md

16. Informant: History given by

Address: Lwen Self

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 5, 1940 (month) (day) (year)

Cemetery or crematory: Millers Station Cemetery

Location: near Manchester Md

18. Funeral director: W. A. Feiser

Address: Hanover, Pa

19. 9/3 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-3 1940, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-6-40 1940, to 9-3- 1940, and that I last saw him alive on 9-2- 1940.

Immediate cause of death: Neuro vascular syphilis — DURATION: many years

Due to

Due to: Pulmonary Congestion — 5 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: No

Of autopsy: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Stone M. D. or other

Address: Westminster Date signed: 9-3-

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

09466

CERTIFICATE OF DEATH

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Uniontown

(If outside city or towu limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Uniontown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Nora B. Gilbert

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife G. Fielder Gilbert

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1885

8. AGE: Years	Months	Days	If less than one day
55	0	14	hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George W. Slonaker

13. Birthplace Md

MOTHER 14. Maiden name Emma Myerly

15. Birthplace Md

16. Informant G. Fielder Gilbert

Address Uniontown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 23, 1940 (month) (day) (year)

Cemetery or crematory Uniontown Ch of God

Location Uniontown, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Sept. 23 1940 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1940, at 4:30 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 20 1940, to Sept. 20 1940, and that I last saw h[illegible] alive on Sept. 18 1940.

	DURATION
Immediate cause of death Cancer of the Breast with metastases to bone.	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

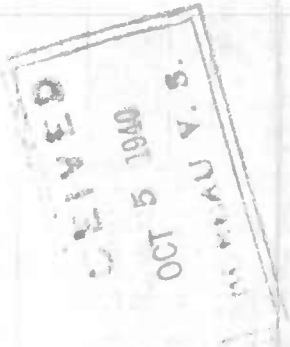
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Milton A. Katz M.D. M. D. or other

Address Westminster Md. Date signed 9-22-40

63 W Main



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-B)

CERTIFICATE OF DEATH

09467

Reg. Dist. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 28 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy. Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) If VETERAN, NAME WAR: No.

3. (a) FULL NAME: Sarah Amanda Hahn

3. (b) Social Security Number: No

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married.

6 (b) Name of husband ~~or wife~~: Melvin Hahn

6(c) If alive, give age: 69. years

7. Birth date of deceased (mo., day, yr.): May 5, 1864

8. AGE:

Years	Months	Days	If less than one day
76	4	12	hrs. min.

9. Birthplace: Frederick Co. Md.

(Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business

FATHER

12. Name: Benjamin Hood.

13. Birthplace: Maryland

MOTHER

14. Maiden name: Sarah Harnisan

15. Birthplace: Maryland.

16. Informant: Mr. Melvin Hahn

Address: Mt. Airy. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20, 1940 (month) (day) (year)

Cemetery or crematory: Taylorsville

Location: Taylorsville. Md.

18. Funeral director: C. M. Waltz

Address: Mt. Airy Md

19. Sept. 19 1940 (Date rec'd by registrar) Wm. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17 1940 at 1:35 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 3 1940 to Sept 17 1940 and that I last saw her alive on Sept 17 1940.

	DURATION
Immediate cause of death: Carcinoma of Uterus with General Metastasis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. M. Van Poole M. D. or other

Address: Mt Airy Md Date signed 9/18-40

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

09468

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Jennie S. Hanson

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: W. H. Hanson
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 15. 1868

8. AGE:

Years	Months	Days	If less than one day
71	9	00	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: David H. Hoffacker
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary E. Shuemans
15. Birthplace: Unknown
16. Informant: Mrs. John Hughes
Address: Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-17-40 (month) (day) (year)
Cemetery or crematory: Manchester
Location: Manchester Md
18. Funeral director: Jacob Winter's Sons
Address: Manchester Md
19. Sept. 16 1940 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 1940, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1940 to Sept 15 1940, and that I last saw her alive on Sept 14 1940.

	DURATION
Immediate cause of death: Cancer of stomach	6 mos
Due to:	
Due to:	
Other conditions: Hypertension & mitral insufficiency. (Include pregnancy within 3 months of death)	

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: W. P. S. Demuth M. D. or other
Address: Manchester, Md Date signed 9/15/40

RECEIVED
OCT 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

09469

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 1 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 2months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Calvert
City or town: Wilson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EDYTHE ELIZABETH HARROD

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Lemuel Harrod
Wilson, Maryland 6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.): September 29, 1899

8. AGE: Years	Months	Days	If less than one day
40	10	13	...hrs. ...min.

9. Birthplace: Plum Point, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Unknown

FATHER
12. Name: Willie Diggs
13. Birthplace: Plum Point, Maryland

MOTHER
14. Maiden name: Liza Jane Commodore
15. Birthplace: Plum Point, Maryland

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15/1940 (month) (day) (year)
Cemetery or crematory: Plum Point
Location: Calvert Co Md
18. Funeral director: D E Sewell
Address: Prince Frederick Md

19. Sept. 12 1940 (Date rec'd by registrar) Albert R. Sewell Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12th. 1940 at 5:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11th. 1940 to September 12 1940 and that I last saw her alive on September 12th. 1940

Immediate cause of death	DURATION
Uremia	2 wks.
Due to: Chronic nephritis with hypertension	Dec. 1939
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op. --
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D.
Superintendent
M. D. or other
Address: Henryton, Maryland Date signed 9/12/40

RECEIVED
OCT 4 1940
BUREAU V. S.

09470

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (113)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 6 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 month, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore County

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stonewall Park
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James W. Hawke

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Elizabeth Cogle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October, 6 18 63

8. AGE: Years 76 Months 11 Days 24 If less than one day ..... hrs. ..... min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ---

FATHER
12. Name: Elijah Hawke
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Elizabeth Waltman
15. Birthplace: West Virginia

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 2, 1940 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery

Location: Harpers Ferry W. Va.

18. Funeral director: F. C. Higinbotham

Address: Ellicott City Md.

19. Sept. 30 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 1940, at 2:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24 1940 to Sept. 30 1940 and that I last saw him alive on September 29 1940

Immediate cause of death	DURATION
Generalized Arteriosclerosis	Unknown
Due to	
Due to	
Other conditions: Pulmonary emphysema	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Lewis Danziger M.D. M. D. or other

Address: Sykesville, Md. Date signed: 9-30-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

09471

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(122-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 3 mo 21 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr. 3 mo 21 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1823 West Baltimore St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen Warfield Heckrotte

3.(b) Social Security Number 718-10-8401

4. Sex F.

5. Color or race W.

6.(a) Single, married, widowed, or divorced divorced

6.(b) Name of husband or wife (Unknown) Heckrotte

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 13, 1892

8. AGE: Years 48 Months 5 Days 16 If less than one day ..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Stenographer

11. Industry or business (Unknown)

FATHER
12. Name David H. Warfield
13. Birthplace Maryland

MOTHER
14. Maiden name Mary L. Linthicum
15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 2 1940 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cem.

Location Balto. Md.

18. Funeral director Wm. J. Tickner & Sons

Address North & Pa. Aves

19. Sept. 29 1940 (Date rec'd by registrar) C. Harry Wm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1940 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 28 1940 to Sept. 29 1940 and that I last saw her alive on Sept. 29 1940

Immediate cause of death Intestinal Obstruction — DURATION 9-28-40

Due to Not due to cancer. Caused by adhesions following a former gastro-enterostomy. cwbc

Due to

Other conditions Agitated depression — 9-1937

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D.
M. D. or other

Address Sykesville Md. Date signed 9.29.40

VS A15 (T) (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 4 1940
BUREAU V. S.

09472

76

FACE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Finksburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: (Foot Falls Hill)

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 4665 Park Heights Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: B.T. 1683 Carl F. Helland, Jr.

3. (b) Social Security Number: 215-18-1825

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 8, 1920

8. AGE: Years: 20 Months: 0 Days: 30 If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Steel worker

11. Industry or business:

FATHER
12. Name: Carl F. Helland
13. Birthplace: Maryland

MOTHER
14. Maiden name: Olive Gallagher
15. Birthplace: Maryland

16. Informant: Carl F. Helland

Address: Baltimore, Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof: 9/10/40 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Md

18. Funeral director: Margaret Flynn

Address: Baltimore, Md

19. 9/7 1940 (Date rec'd by registrar) F. Woodward Registrar

MEDICAL CERTIFICATION Prior to

20. DATE OF DEATH: September 7 1940, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —, and that I last saw h — alive on — 19 —.

Immediate cause of death: Fractured Skull, Fractured Maxilla

Due to: Automobile Accident

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 9-7-40

Where did injury occur? Finksburg (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?): Foot of Falls Hill

Means of injury: Automobile Accident Injured at work? No

23. SIGNATURE: Jas. T. March - Deputy Medical Examiner M. D. or other

Address: New Windsor Md Date signed: 9-7-40

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 12 1940

09473

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 2 mos., 25 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs., 2 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Calvin L. Holbert

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: -----

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 1, 1873

8. AGE: Years 67 Months 5 Days 4 If less than one day ..... hrs. ..... min.

9. Birthplace: Washington County, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ------

FATHER

12. Name: Isaac Holbert

13. Birthplace: Maryland

MOTHER

14. Maiden name: Maria Bridendolph

15. Birthplace: Maryland

16. Informant: Records of Springfield State Hospital, Sykesville, Md.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-11-40 (month) (day) (year)

Cemetery or crematory: Springfield Hosp.

Location: Sykesville Md.

18. Funeral director: A. H. Steer

Address: Sykesville Md.

19. Sept. 6 1940 (Date rec'd by registrar) A. Harry Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1940 at 6:45a.m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1940 to Sept. 5 1940 and that I last saw him alive on September 5 1940

Immediate cause of death	DURATION
Pulmonary tuberculosis	6 months
Due to	
Due to	
Other conditions: arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lewis Danziger, M.D. M. D. or other

Address: Sykesville, Md. Date signed 9-5-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09474

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs., 6 mos., 16 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 5 yrs., 6 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.: (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Herbert Edward Holders

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 31, 1899

8. AGE: Years: 40 Months: 10 Days: 1 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farm hand
11. Industry or business: ----

FATHER
12. Name: William Holders
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Rebecca Heron
15. Birthplace: Ohio

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 9, 1940 (month) (day) (year)
Cemetery or crematory: Springfield
Location: Sykesville Md.
18. Funeral director: C. A. Heer
Address: Sykesville Md.
19. Sept 5 1940 (Date rec'd by registrar) C. Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4 1940 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1 1940 to Sept. 4 1940 and that I last saw him alive on September 4 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Lewis Danzig, M.D. M. D. or other
Address: Sykesville, Md. Date signed: 9-4-40

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BUREAU V. S.

See Film 6124 3/10/50 gs

STATE OF MARYLAND—CERTIFICATE OF DEATH

09475

(45-A)

1. PLACE OF DEATH

County Carroll Registration Dist. No. 77

Village or City Hampstead Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME James Thomas Howe

(a) Residence: No. Hampstead Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A. Howe 1868

6. DATE OF BIRTH (month, day, and year): Nov 24, ~~1867~~

7. AGE: Years ~~72~~ 71 | Months 9 | Days 15 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Penna R. R. Conductor

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Md

FATHER

13. NAME: Wm. S. Howe

14. BIRTHPLACE (city or town) (State or country): Md

MOTHER

15. MAIDEN NAME: Ruth E. Bull

16. BIRTHPLACE (city or town) (State or country): Md

17. INFORMANT (Address): Mary A. Howe Hampstead Md.

18. BURIAL, CREMATION, OR REMOVAL

Place: London Park Date: Sept 12, 1940

19. UNDERTAKER (Address): Thenowell & Donovan 3615-17 Chestnut Ave

20. FILED: Sept. 10, 19 Mildred S. Hughes deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept. (Month) 9 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1940, to Sept. 9, 1940

I last saw him alive on Sept. 9, 1940; death is said to have occurred on the date stated above, at 8:00 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
(1) Carcinoma of Lip	1938
(2) Metastatic Carcinoma of Cervical glands	1940
(3) Metastatic Carcinoma of Lungs	2 mo.

Other Contributory Causes of importance:

Name of operation: Excision of Lip growth Date of 1938

What test confirmed diagnosis? Biopsy Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Maurice C. Porterfield M. D.

(Address) Hampstead Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09476

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 month, 22 days
Hospital, institution, or street address where death occurred:
Md. Tuberculosis Sanatorium
Colored Bracnh
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1517 Sahland Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Robert Junior Jackson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age ---

7. Birth date of deceased (mo., day, yr.): August 20, 1920

8. AGE: Years	Months	Days	If less than one day
19	11	29	....hrs. ....min.

9. Birthplace: Cambridge, Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: At school

FATHER
12. Name: Richard Parker
13. Birthplace: Unknown

MOTHER
14. Maiden name: Ella Jackson
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21, 1940 (month) (day) (year)
Cemetery or crematory: Waugh Chapel
Location: Cambridge Md
18. Funeral director: Lewis H Baumeum
Address: Cambridge Md

19. 9/18/40 (Date rec'd by registrar) 19.... Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18, 1940 at 4.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1940 to Sept., 18, 1940 and that I last saw him alive on September 18 1940

Immediate cause of death: Tuberculosis of Spine — DURATION: March, 13th. 1939
Due to: --
Due to: ---
Other conditions: ----
(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op.:
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: -- Injured at work? ---

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 9/18/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

09477

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 1 month, 19 days

Stay in this community (yrs., or mos., or days): same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: none

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: George Stanley Keith

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): October 13, 1911

8. AGE:

Years	Months	Days	If less than one day
28	10	25	---- hrs. ---- min.

9. Birthplace: Remington, Va. (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: unknown

FATHER — 12. Name: Joseph Keith

FATHER — 13. Birthplace: Prince George's County, Md.

MOTHER — 14. Maiden name: Marie Smith

MOTHER — 15. Birthplace: Remington, Virginia

16. Informant: Reuben Hoffman, M. D.; Address: Henryton, Maryland

17. Removal to Washington D.C. Sept. 7, 1940 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or ~~crematory~~: Remington

Location: Fairfax County Va.

18. Funeral director: George W. Lewis & Co

Address: 2032 - 8th Street N.W.

19. Sept. 7 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

1:40PM

20. DATE OF DEATH: September 7 1940, at ---

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1940, to September 7 1940, and that I last saw him alive on September 7 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb 1940
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 9/7/40

Superintendent

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

09478

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ months

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1½ months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2011 E. Ellsworth St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Kraft

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of ~~husband or~~ wife: Mrs. Florence Kraff

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1882

8. AGE: Years	Months	Days	If less than one day
57	10	21	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business:

FATHER — 12. Name: John Kraft

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: Mary Galatea

MOTHER — 15. Birthplace: Unknown

18. Informant: Mrs. Florence Kraff (wife)

Address: 2011 E. Ellsworth St. Balto Md

17. Burial, cremation, or removal (Which?) Burial Date thereof: 9-11-40 (month) (day) (year)

Cemetery or crematory: Schwartz

Location: Balto.

18. Funeral director: Philip Herring Sons

Address: 2324 Ellsworth

19. Date rec'd by registrar: Sept 8 1940

Registrar: Nancy Keen

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 8 1940, at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1940, to Sept 8 1940

and that I last saw him alive on Sept. 8 1940

	DURATION
Immediate cause of death: Cerebral Embolism	Aug. 26, 1940
Due to: Chronic Endocarditis	known
Due to:	July 29, 1940
Other conditions: Arteriosclerosis	known
(Include pregnancy within 3 months of death)	July 29, 1940

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. – M. D. or other

Address: Sykesville, Md. Date signed: Sept. 8, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(45-6)

CERTIFICATE OF DEATH

09479

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 19 John Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 57 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 19 John Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary S. Leahy

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 23, 1883

8. AGE: Years	Months	Days	If less than one day
57	5	21	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Martin J. Leahy
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. McIrenney
15. Birthplace: Maryland

16. Informant: Miss Julia M. Leahy
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/17/40 (month) (day) (year)
Cemetery or crematory: St. John's Catholic
Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 9/14 (Date rec'd by registrar) 1940 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13, 1940, at 11 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 to 9-13- 1940; and that I last saw h alive on 9-13- 1940.

Immediate cause of death	DURATION
Cancer (lower intestine) -	
Hypertension	
Due to Syphilis (acute)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. C. Jennells M.D.
M. D. or other
Address: Westminster Md Date signed: 9-14-40

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OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09480

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months 22 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch (same as Above)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2219 N. Howard St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Velma Lewis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1926

8. AGE: Years	Months	Days	If less than one day
14	4	8	hrs. min.

9. Birthplace: Rock Mount, N. C. (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business: At school

FATHER
12. Name: Isreal Garrett
13. Birthplace: Battlesboro, N. C.

MOTHER
14. Maiden name: Johanna Lewis
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-20-40 (month) (day) (year)
Cemetery or crematory: Rocky Mount N C
Location: Rocky Mt. N. C
16. Funeral director: Archibald C. Geddie
Address: 2101 Mc Culloh St

19. 9/18/40 (Date rec'd by registrar) 19 Albert R. Swanbacker Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 1940 at 12.15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27, 1940 to Sept. 18, 1940 and that I last saw her alive on Sept. 18, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec., 1939
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations ---
Date of op.
Autopsy results ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 9/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)(a)

CERTIFICATE OF DEATH

09481

Reg. Dist. No. 7 J

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Manchester Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 19 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jonas Myers Tippy.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower.

6 (b) Name of husband or wife Clara May Tippy
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1864

8. AGE: Years	Months	Days	If less than one day
76	1	8	____ hrs. ____ min.

9. Birthplace Manchester Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Agriculture
FATHER 12. Name Henry Tippy
13. Birthplace Maryland
MOTHER 14. Maiden name Elandra Myers.
15. Birthplace Pennsylvania
16. Informant Carvin Tippy
Address Hanover Pa R.F.D #2
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 3 1940 (month) (day) (year)
Cemetery or crematory St Davids Shrine
Location Hanover Pa R.D. York Co.
18. Funeral director W. G. Fenner
Address Hanover Pa.
19. Sept. 30 1940 (Date rec'd by registrar) Mrs. W. G. Fenner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1940, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28 1940 to Sept 30 1940 and that I last saw him alive on Sept 30 1940

Immediate cause of death	DURATION
Coronary Occlusion	2 Days
Due to Arterio-Sclerotic Cardio-Renal Disease	?
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph E. Buck M.D.
M. D. or other
Address Hampstead Md. Date signed 9-30-40

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

09482

CERTIFICATE OF DEATH

Reg. Dist. No. 74

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 14 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 7 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 335 North Gay Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Frank McCardell (Macardell)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -----
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6, 1877

8. AGE: Years	Months	Days	If less than one day
63	3	26	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: None

FATHER
12. Name: Francis McCardell
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Garry
15. Birthplace: Ireland

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5, 1940 (month) (day) (year)
Cemetery or crematory: Cathedral Cemetery
Location: Balto. Md.
18. Funeral director: Wm Cook
Address: 1217 St Paul St. Balto. Md.
19. Sept. 3 1940 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2nd 1940 at 9:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 1940 to Sept. 2 1940 and that I last saw him alive on September 2, 1940

Immediate cause of death	DURATION
Chronic Myocarditis and myocardial degeneration	Known 1/19/40
Due to: Arteriosclerosis	10 yrs.
Due to:	
Other conditions: Cardiac decompensation	6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M Virginia Boyer M.D.
M. D. or other
Address: Sykesville, Md. Date signed: Sept 3-1940

RECEIVED
SEP 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-D)

CERTIFICATE OF DEATH

B 9483

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Lyksville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 1 mo. 6 da.
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 1 yr. 1 mo. 6 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto Co.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 501 Ls. 47th St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret McCormick

3.(b) Social Security Number

4. Sex: F.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married.
6.(b) Name of husband or wife: Raymond McCormick
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 20, 1896.
8. AGE: Years 44 | Months 6 | Days 24 | If less than one day ..... hrs. ..... min.
9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None
FATHER 12. Name: John Burns
FATHER 13. Birthplace: Baltimore Maryland
MOTHER 14. Maiden name: Lena (illegible)
MOTHER 15. Birthplace: Melbourne
16. Informant: Hospital Records
Address: Lyksville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/19/40 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Balto Md
18. Funeral director: William Cook
Address: 1217 St. Paul st Balto Md
19. Sept 17 1940 (Date rec'd by registrar) C. Harry Weber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16 1940, at 6.45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1940 to Sept 16 1940 and that I last saw h.. alive on Sept 16 1940

	DURATION
Immediate cause of death: Carcinoma of the	Unknown
Due to: Prostate	
Due to:	
Other conditions: Bedsore, cachexia	4 yrs
Due to: Genital Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maud N. Rees M.D. M. D. or other
Address: Lyksville Md. Date signed 9-16-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 18 1940
BUREAU V. S.

09484

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs., 8 mos., 6 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 8 yrs., 8 mos., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Smithsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D. #2
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Miner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sally Weaver

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 7, 1876

8. AGE:

Years	Months	Days	If less than one day
64	2	19	..... hrs. ..... min.

9. Birthplace: Washington County
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: George F. Miner
13. Birthplace: Washington Co.

MOTHER
14. Maiden name: Amanda Miller
15. Birthplace: Washington Co.

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 29 1940 (month) (day) (year)

Cemetery or crematory: Mt. Vern. Cemetery

Location: Ringgold, Md.

18. Funeral director: Fred W. Krain

Address: Hagerstown, Md.

19. Sept. 27 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26, 1940, at 10:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20 1932 to Sept. 26 1940 and that I last saw him alive on Sept. 26 1940

Immediate cause of death	DURATION
Myocardial degeneration.	8 yrs.
Generalized arteriosclerosis	8 yrs.
Due to Chronic nephritis	7 yrs.
Pulmonary tuberculosis	8 days
Due to	
Other conditions Epilepsy	54 yrs.
Fracture of rib due to accidental fall (Include pregnancy within 3 months of death)	13 days

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 9-26-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09485

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2406 St. Paul St. 2506 Maricourt ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Myra M. Parlett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
80-85?			..... hrs. ..... min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace " "

MOTHER 14. Maiden name: Unknown

15. Birthplace " "

16. Informant: Hospital Records

Address Sykesville, Md.

17. Burial Date thereof Sept. 5, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Baltimore Md.

18. Funeral director Guy Cook

Address 1217 St Paul St. Balto. Md.

19. Sept. 3 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1940, at 4:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1940, to September 3 1940 and that I last saw h... alive on September 3 1940

Immediate cause of death	DURATION
Arteriosclerosis	More than 2 years
Due to	
Due to	
Other conditions Pellagra	Known Aug. 30-1940

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Berger M.D. (M. D. or other)

Address Sykesville, Md. Date signed Sept. 3-1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

09486

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos - 17 days.
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 5 mos - 17 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ~~Maryland~~ VA. County: Baltimore
City or town: ~~Baltimore~~ MILLENBACH (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ANNIE MARIE RAYNER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Frank Rayner
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 5, 1880

8. AGE: Years	Months	Days	If less than one day
60	4	17	..... hrs. ..... min.

8. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business

FATHER
12. Name: ? Taylor
13. Birthplace: ? Maryland

MOTHER
14. Maiden name: ?
15. Birthplace: ? Maryland

18. Informant: Mrs. Rosalie Pritchard
Address: Millenbach, Virginia.

17. Buried (Burial, cremation, or removal: Which?) Date thereof: Sept 24 40 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore Md
18. Funeral director: George L. Lohrob
Address: 2101 Frederick Ave
19. Sept. 22 1940 (Date rec'd by registrar) Nancy Green Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 22 19 40 at 11 35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 19 40, to Sept. 22 19 40
and that I last saw her alive on Sept. 22 1940 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 wks.
Due to: Hypertensive Arteriosclerotic Cardiovascular Dis.	4 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D.
M. D. or other
Address: Sykesville, Md. Date signed 9-22-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 26 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

09487

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 75 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Frederick
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME Miss M.Louise Reindollar

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6 (b) Name of husband or wife none
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27,1850

8. AGE:

Years	Months	Days	If less than one day
89	10	26	hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation housework
11. Industry or business
FATHER 12. Name James Reindollar
13. Birthplace Md
MOTHER 14. Maiden name Ursula Galt
15. Birthplace Md
16. Informant Norman Reindollar
Address Taneytown, Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof Sept.26,1940 (month) (day) (year)
Cemetery or crematory Lutheran
Location Taneytown, Md.
18. Funeral director C.O.FUSS & SON
Addresa Taneytown, Md.
19. Sept. 26, 1940 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1940, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1937, to Sept. 23, 1940, and that I last saw her alive on Sept. 23, 1940

Immediate cause of death	DURATION
Chronic Interstitial Nephritis	3yrs
" Myocarditis	3 yrs.
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Francis D. Elliot M.D.
M. D. or other
Address Taneytown, Maryland Date signed Sep. 25

RECEIVED
OCT 2 1940
U. S. DEPT. OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92E)

09488

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: William F. Roll

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Barbare E. Arnold

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19, 1872

8. AGE: Years	Months	Days	If less than one day
68	3	21	hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Frederick Roll
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Roll
15. Birthplace: Germany

16. Informant: Delmas Roll
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/12/40 (month) (day) (year)

Cemetery or crematory: Deer Park Cemetery

Location: Smallwood, near Westminster

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 9/11 (Date rec'd by registrar) 19 40 H. E. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 1940, at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Sept. 1st 1935, to Sept. 9th 1940, and that I last saw him alive on Sept. 9 1940.

	DURATION
Immediate cause of death: Chronic Valvular Heart Disease	Several years
Due to: Mitral and Aortic Regurgitation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. Billingslea M. D. or other

Address: Westminster, Md. Date signed 9/11/40.

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

09489

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Westminster

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 78 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Westminster Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: George A. Shipley

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Emily J. Wagner

6(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): November 30, 1861

8. AGE: Years	Months	Days	If less than one day
78	9	8	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Grove A. Shipley

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary A. Brothers

15. Birthplace: Maryland

16. Informant: Mrs. Emily J. Shipley

Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/10/40 (month) (day) (year)

Cemetery or crematory: Westminster

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 9/9 40 (Date rec'd by registrar) 19 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1940, at 9p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16- 1940, to Sept 7, 1940, and that I last saw him alive on Sept 7. 1940

Immediate cause of death	DURATION
Arteriosclerosis & acute cardiac dilatation	1937
Due to	Sept 7 1940
Due to Fracture Left Femur. Due to and	July 3-1940
Other conditions accidental fall. Cut S.C. While walking on kitchen floor. (Include pregnancy within 3 months of death)	

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) In his home

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: Chas R Tout M.D. M. D. or other

Address: Westminster Md. Date signed 9-9-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

215-18-1825

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

09490

CERTIFICATE OF DEATH

Reg. Dist. No. 81.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Elger Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Elger Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John William Sisk

3. (b) Social Security Number 213-03-1020

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Nora Otto Sisk

6(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Aug 27 - 1874

8. AGE:

Years	Months	Days	If less than one day
66	0	5	hrs. min.

9. Birthplace Keysville, Carroll Co, Md.

(Town, county, and state)

10. Usual occupation Oiler (Retired)

11. Industry or business Cement Plant.

FATHER

12. Name David Sisk

13. Birthplace Not Known.

MOTHER

14. Maiden name Mary E. Hollenberry

15. Birthplace Not Known.

16. Informant Mrs Nora O Sisk

Address Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4. 1940 (month) (day) (year)

Cemetery or crematory Middleburg Methodist Cem

Location Middleburg Md

18. Funeral director D. D. Hartle & Son.

Address Union Bridge, Md.

19. Sept. 4 1940 (Date rec'd by registrar) Reichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1940, at 11 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1940 to Sept 1 1940, and that I last saw h- im alive on Sept 1 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to Probably alcoholic drinks in early years	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M. D. or other

Address Union Bridge Date signed 9-1-40

RECEIVED
OCT 5 1940
BUREAU V. S.

09491

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll.
City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 3 mos., 9 days.
Hospital, institution, or street address where death occurred: Springfield State Hospital.
How long in hospital or institution? 1 yr., 3 mos., 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland, County
City or town Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 34 North Ellwood Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME David M. Smith.

3. (b) Social Security Number #

4. Sex: Male.
5. Color or race: White.
6.(a) Single, married, widowed, or divorced: Widowed.
6.(b) Name of ~~husband or~~ wife: Elizabeth Dimnick.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): August 15, 1861.

8. AGE: Years 79. Months 0. Days 18. If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland. (Town, county, and state)
10. Usual occupation: Foreman.
11. Industry or business: Penn. R. R.

FATHER
12. Name: Phillip Smith,
13. Birthplace: Germany.

MOTHER
14. Maiden name: Elizabeth Russell,
15. Birthplace: Maryland.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof ~~Aug~~ Oct. 6/40 (month) (day) (year)
Cemetery or crematory: Balto. Cem
Location: North Ave.
18. Funeral director: Lilly & Zeiler Inc
Address: 403 S. Wolbe St.
19. Sept. 3 1940 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2, 1940, at 6.25 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9, 1939, to Sept. 2, 1940, and that I last saw him alive on Sept. 2, 1940.

	DURATION
Immediate cause of death: Chronic Myocardial Degeneration prior to	5-24-39.
Due to: General Arteriosclerosis with Hypertension prior to	5-24-39.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Harry F. Baer, M.D. M. D. or other
Address Sykesville, Md. Date signed 9-2-40.

VS A15 (T) (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09492

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 yrs. 4 mos. 6 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 39 yrs. 4 mos. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: La Plata (?)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Francis Speake

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Unknown

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1856. Exact date unknown.

8. AGE: Years	Months	Days	If less than one day
84	Unk.	Unk.	..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Springfield Hospital Record
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16 1940 (month) (day) (year)
Cemetery or crematory: Springfield Hospital Cem.
Location: Sykesville Md.

18. Funeral director: O.A. Beer
Address: Sykesville Md.

19. Sept 12 1940 (Date rec'd by registrar) O. Harry Beer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11, 1940 at 9:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1936 to Sept. 11, 1940 and that I last saw him alive on Sept. 11, 1940

Immediate cause of death	DURATION
Acute Broncho-Pneumonia	3 days
Due to:	
Due to:	
Other conditions: Chronic Myocarditis	5 years
Dementia Praecox - prior to 5-4-'01	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D.
M. D. or other
Address: Sykesville, Md. Date signed: 9-11-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

09493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-t)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 1 mo., 2 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 1 yr., 1 mo., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Eagle Street (number not known)
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Franklin Mooney alias Milton Stewart

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ----
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 6, 1873

8. AGE:

Years	Months	Days	If less than one day
67	4	15	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: None- odd jobs
11. Industry or business: ----

FATHER
12. Name: Joseph Mooney
13. Birthplace: Baltimore, Maryland.

MOTHER
14. Maiden name: Elizabeth Dockman
15. Birthplace: Baltimore, Maryland

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address:

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Sept 23 1940 (month) (day) (year)
Cemetery or crematory: Springfield Hosp.
Location: Sykesville Md.

18. Funeral director: C. H. Heer
Address: Sykesville Md.

19. Sept 22 1940 (Date rec'd by registrar) C. Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21st 1940, at 6:00a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1940, to Sept. 21 1940 and that I last saw him alive on Sept 20 1940

Immediate cause of death	DURATION
TBC peritonitis	unknown
Due to TBC colitis	unknown
Due to Pulmonary tbc, disseminated	over 1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Lewis Danzign. M.D. M. D. or other
Address: Sykesville, Md. Date signed: 9-21-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

09494

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs., 7 mos., 29 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 17 yrs., 7 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore, Md.

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 512 S. Dunbarton St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Dolly Stirling (Ella Tull)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years: 62 Months: Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Somerset County, Md. (Town, county, and state)

10. Usual occupation: Printers helper

11. Industry or business:

FATHER — 12. Name? Wm. H. Tull

13. Birthplace? Crisfield, Md

MOTHER — 14. Maiden name? Catherine Lankford

15. Birthplace? Crisfield, Md

18. Informant: Hospital records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 2 1940 (month) (day) (year)

Cemetery or crematory: Mt. Carmel Balto Md

Location: O'Donald Street

18. Funeral director: George E. Pentz Inc.

Address: 1726 Hanford Ave.

19. Oct. 1 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sep. 30 1940 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1, 1923 to Sep. 30, 1940 and that I last saw h... alive on Sep. 24, 1940

Immediate cause of death	DURATION
General paresis	18 yrs.
Due to: Hypertensive cardiovascular disease	18 yrs.
Due to: Hypostatic pneumonia	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 10-1-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09495

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 2 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 945 Sharp St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie Laura Thomas

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 11, 1923

8. AGE: Years	Months	Days	If less than one day
17	1	10	hrs. min.

9. Birthplace: Richmond, Virginia (Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business: Unknown
FATHER 12. Name: Wallace Thomas
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Marie Brewer
MOTHER 15. Birthplace: South Carolina
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 25-40 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Balto Md
18. Funeral director: Isaiah L Brown Son
Address: 108 W Montgomery St
19. Sept. 21 1940 (Date rec'd by registrar) Albert R. Swanborn Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21, 1940 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19th. 1940 to Sept. 21 1940 and that I last saw h...er alive on September 21st. 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1938
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op. --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Superintendent
Address: Henryton, Maryland Date signed 9/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 30 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

09496

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 month, 18 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch (same as above)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicimico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 127 E. Rose
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Blanche Mae Trader

3.(b) Social Security Number: 213-14-6356

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 17, 1922

8. AGE:

Years	Months	Days	If less than one day
18	5	1	..... hrs. ..... min.

9. Birthplace: Salisbury, Md.
(Town, county, and state)

10. Usual occupation: Maid

11. Industry or business: Unknown

FATHER
12. Name: Archie Trader
13. Birthplace: Salisbury, Md

MOTHER
14. Maiden name: Sarah Long
15. Birthplace: Pocomoke City, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 21-1940 (month) (day) (year)

Cemetery or crematory: Houston

Location: Salisbury Md

18. Funeral director: James H. Stewart
Address: Salisbury Md

19. 9/18/40 (Date rec'd by registrar) 19 Deputy Local Registrar: Albert R. Swankhaus

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept., 18, 1940 19 ....., at 6.00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31, 1940, to Sept., 18 1940 and that I last saw her alive on September 18, 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 1940

Due to: ---

Due to: ---

Other conditions: ---
(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)

Address: Henryton, Md. Date signed: 9/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09497

(107)

CERTIFICATE OF DEATH

Reg. Diat. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Springfield State Hospital.

How long in hospital or institution? a month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 W. Howard St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary J. Tribby

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Lutzmann.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 21. 1880

8. AGE: Years	Months	Days	If less than one day
60		28	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: John Conard

13. Birthplace: Va.

MOTHER 14. Maiden name: Mariah Demory

15. Birthplace: Va

16. Informant: Eugene W. Tribby (Son)

Address: 109 3rd St. Richmond, Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown Md.

18. Funeral director: C. M. Fuller & Sons

Address: Hagerstown Md.

19. Sept 18 1940 (Date rec'd by registrar) Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18, 1940, at 7:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 17 1940, to Sept. 18 1940

and that I last saw h[illegible] alive on Sept. 17 1940

Immediate cause of death	DURATION
Confluent lobular pneumonia	24 hrs.
Due to: Arteriosclerosis unknown	
Due to:	
Other conditions: Hypertension r Arteriosclerosis	4 Known [illegible]

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: As above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lewis Danziger M. D. M. D. or other

Address: Sykesville, Md. Date signed 9-18-40

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09498

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1month., 12 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 1 months., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1808 Madison Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: EDGAR COLUMBUS TYLER

3.(b) Social Security Number: no

4. Sex: male
5. Color or race: colored
6.(a) Single, married, widowed, or divorced: Married (separated)
6.(b) Name of husband or wife: Gertrude Tyler
6.(c) If alive, give age: 24 years
7. Birth date of deceased (mo., day, yr.): November 10, 1904
8. AGE: Years: 35 Months: 11 Days: 17 If less than one day: ..... hrs. ..... min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Interior decorator
11. Industry or business: Unknown
FATHER 12. Name: William Tyler
FATHER 13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Bessie Quince
MOTHER 15. Birthplace: York, Pennyslvania
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 30 40 (month) (day) (year)
Cemetery or crematory: ST. PETERS CEM.
Location: BALTIMORE MD
16. Funeral director: WILLIAM A JACKSON
Address: 916 PENNA-AVE.
19. Sept. 27 1940 (Date rec'd by registrar) Albert R. Swanblade Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27th 1940 at 2:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15th. 1940, to Sept. 27th 1940 and that I last saw him alive on September 27th. 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1940
Due to: --	
Due to: --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op.: --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 9/27/40

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

RECEIVED
OCT 4 1940
BUREAU V. S.

09499

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mo and 26 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 8 mo and 26 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Monta

City or towe Kensington, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Josephine Van Horn

3. (b) Social Security Number

4. Sex F.

5. Color or race W.

6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife (Mulen) Van Horn

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1893

8. AGE: Years 47 Months 8 Days 13 If less than one day hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William McKay
13. Birthplace Unknown

MOTHER
14. Maiden name Elizabeth Lang
15. Birthplace Unknown

16. Informant Hospital Records
Address Sykesville, Md.

17. ~~(Burial, cremation, or~~ removal, ~~Which?)~~ Date thereof Sept 10 1940 (month) (day) (year)

Cemetery or crematory Silver Spring,
Location Maryland

18. Funeral director Warner E. Pumphrey
Address Silver Spring Md.

19. Sept 10 1940 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9, 1940 at 11.40 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1940 to Sept 9 1940 and that I last saw her alive on Sept 9 1940.

Immediate cause of death	DURATION
Arteriosclerosis	1938
Due to	
Due to Cerebral Hemorrhage	7 da
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maud M. Rice M.D. M. D. or other

Address Sykesville Md. Date signed 9-9-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (946) Reg. Dist. No. 09500 50

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Church St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town New Windsor Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Church
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Theodore Kurtz Warner

3 (b) If veteran, name war none
3 (c) Social Security No. None

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Cora E Warner
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3 1879

8. AGE: Years 62 Months 11 Days 9 If less than one day hr. min.

9. Birthplace Carroll Co. Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Alfred Warner
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Mary E Myers
15. Birthplace Carroll Co Md

16 (a) Informant Mrs Cora Warner
(b) Address New Windsor Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14 40 (month) (day) (year)
(c) Cemetery or crematory Winters Cemetery
Location Near New Windsor

18 (a) Funeral director D D Harkler & Sons
(b) Address New Windsor Md

19 (a) Sept 14 40 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. Date of death Sept 11 1940, at 1-A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1940, to Sept 11 1940, and that I last saw him alive on Sept 10 1940.

Immediate cause of death Angina Pectoris — Duration
Due to
Due to Myocardial weakness Low Blood pressure
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Legg M. D. or other
Address Union Bridge Date signed 9-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09501

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 16 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 2 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1319 Madison Avenue (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: JAMES EDWARD WEEMS

3.(b) Social Security Number: 215-12-1626

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 6, 1923

8. AGE: Years	Months	Days	If less than one day
17	8	18	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business: Unknown

FATHER
12. Name: James Weems
13. Birthplace: Burkettsville, Maryland

MOTHER
14. Maiden name: Frances Adams
15. Birthplace: Easton, Maryland

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27 1940 (month) (day) (year)
Cemetery or crematory: Mt. Calvery Cemetery
Location: Anne Arundel County
18. Funeral director: Mrs. Geo. H. Holland
Address: 1631 Hanover Hill Ave

19. Sept. 24th 1940 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24th. 1940 at 2:16 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8th. 1940 to Sept. 24th. 1940 and that I last saw him alive on September 24th. 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1940
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op.: --
Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 9/24/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-6)

09502

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Near Taneytown Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 15 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Mr. Taneytown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Nettie Ivy Welty

3. (b) Social Security Number: None

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harry Welty

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5 1895

8. AGE: Years: 45 Months: 4 Days: 11 If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: House Work

11. Industry or business:

FATHER 12. Name: Greenberry Gearhart

13. Birthplace: Md

MOTHER 14. Maiden name: Esther Shipley

15. Birthplace: Md

18. Informant: LeRoy Wantz

Address: Littlestown Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 18 1940 (month) (day) (year)

Cemetery or crematory: Keysville

Location: Carroll Co Md

18. Funeral director: C O Fuss & Son

Address: Taneytown Md

19. Sept 17. 1940 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1940, to Sept. 16 1940, and that I last saw her alive on Sept. 16 1940

Immediate cause of death	DURATION
Exopthalmic Goitre	4 Mos.
Due to	
Due to	
Other conditions: Mitral Stenosis (Rheumatic)	3 Years
High Blood Pressure	3 Years

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. S. McVaugh M.D.
M. D. or other

Address: Taneytown, Md. Date signed 9/16/40

RECEIVED
OCT 2 1940
BUREAU V. S.

09503

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: Harry Wilt

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Catherine I. Wilt

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 8, 1876

8. AGE:

Years	Months	Days	If less than one day
64	2	4	____ hrs. ____ min.

9. Birthplace: York County, Pennsylvania
(Town, county, and state)

10. Usual occupation: Farm labor

11. Industry or business

FATHER
12. Name: Jesse Wilt
13. Birthplace: York Co., Pennsylvania

MOTHER
14. Maiden name: Frances Fickes
15. Birthplace: York Co., Pennsylvania

16. Informant: Walter W. Futer
Address: York, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/16/40 (month) (day) (year)

Cemetery or crematory: Wolf Church Cemetery

Location: York County, Pa.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 9/12 1940 (Date rec'd by registrar) L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1940, at noon 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Had not had a doctor for some days. 19__, to 19__, and that I last saw h__ alive on 19__.

Immediate cause of death: Acute Cardiac [illegible] (Dilatation) Few minutes

Due to: Myocardial Degeneration Some years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. L. Billingslea, M.D. acting ~~Coroner~~ Medical Examiner M. D. or other

Address: Westminster, Md. Date signed: 9/12/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1940
BUREAU V. S.

09504

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 15 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rella Grace Wright

3. (b) Social Security Number none

4. Sex F

5. Color or race n

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Roy L. Wright

6(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) April 5 - 1890

8. AGE: Years 50 Months 5 Days 18 If less than one day hrs. min.

9. Birthplace Needmore Fulton Co. Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Barton Mollett
13. Birthplace Penn.

MOTHER
14. Maiden name Ida A. Wink
15. Birthplace Penn.

16. Informant Roy L. Wright
Address Westminster Md. R.D.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept. 26. 1940 (month) (day) (year)

Cemetery or crematory Bellsville Cemetery

Location Bellsville, Montgomery Co. Md

18. Funeral director H Bankard & Son
Address Westminster, Maryland

19. 9/28 1940 L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1940, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 , to — 19 ,
and that I last saw h alive on — 19 .

Immediate cause of death Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy None

DURATION ?

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Jas. T. Marsh Deputy Medical Examiner
M. D. or other
Address New Windsor Md Date signed 9/23/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1940
BUREAU V. S.